STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr South Loop	1725 South Wabash Chicago, IL 60616

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review that facility failed to provide adequate supervision for one (R1) resident in a sample of four reviewed. This failure has the potential to affect all residents who need an escort while out of the facility on an appointment.R1's current face sheet documents R1 is a [AGE] year-old individual with medical diagnoses that include but not limited to: other encephalopathy, opioid abuse, uncomplicated, malignant neoplasm of overlapping sites of left female breast. MDS (Minimum Data Set) section C dated Sep 29, 2025, documents R1's Brief Interview for Mental Status (BIMS) as 12/15 indicating R1 has moderate cognitive impairment.On 09/30/2025 at 10:24 AM, V3 (Registered Nurse-RN) stated R1 needs an escort to appointments for safety because R1 gets confused and R1 can be in danger of getting lost or being abused if R1 goes to appointments alone.On 09/30/2025 at 12:19 PM, V5 (Work Clerk) stated he schedules appointments for residents and if a resident does not have intact cognitive abilities, an escort is scheduled to accompany the resident to appointments. V5 stated on 09/29/2025, R1's methadone appointment was scheduled for 09/29/2025, at 8:00AM. An escort was scheduled to accompany R1. V5 stated he got a call from V6 (As needed Escort) at 7:42AM stating V6 had an emergency and would not be able to make it to work on time to assist or take R1 to her appointment. V5 stated R1 was picked up by transportation at 7:45AM without an escort. V5 stated he tried to call R1's nurse (does not know who the nurse was) to let the nurse know R1 needed an escort but the phone on R1's unit was not answered. V5 stated he spoke to V10 (Lead receptionist) who stated R1 had already left for her methadone appointment with transportation without an escort.V5 stated all residents on Methadone are sent to the clinic with an escort because the resident comes back to the facility with a supply of Methadone medication to last the resident for a week until the next appointment and Methadone is a controlled substance. V5 stated escorts are scheduled to take a resident to the Methadone clinic for safety reasons and to bring the methadone back to the facility safely.V5 stated it's his responsibility to make sure a resident on Methadone goes to appointment with an escort. V5 stated escorts are trained on keeping residents safe while out of facility for appointment.On 09/30/2025 at 11:15AM, V14 (Certified Nursing Assistant -CNA) stated R1 is confused and forgetful at times, is not able to make decisions, talks about things that are not there, has told V14 that there is someone outside of R1's window when there is no one, and R1 forgets who V14 is although V14 works with R1 regularly. V14 stated R1 can be unsafe in the community by herself because she is forgetful and might not know how to get back to the facility. R1 can get hurt out there in the community if she is by herself.On 09/30/2025 at 2:27PM, V2 (Director of Nursing-DON) stated it is best practice for a resident to have an escort when going to a Methadone clinic because Methadone is a controlled substance, therefore, staff from the facility should be present to make sure the resident's Methadone from the clinic is coming back to the facility safely because Methadone can be abused. V2 stated R1 is alert and oriented times 2-3, meaning R1 has some periods of confusion and should always have an escort for safety reasons when going out of the facility to appointment. V2 stated R1 should not have left the facility without an escort. V2 stated it's the nurse's responsibility to check which resident needs an escort before sending the resident out to an appointment. V2 stated there is an appointment sheet by the nursing station documenting all resident appointments, time of appointment and if an escort is needed. V2 stated V5 (Work Clerk) schedules appointments and indicates on the appointment book who needs an escort.On 09/30/2025 at 1:50PM, V8 (Licensed Practical Nurse-LPN) stated via phone that the CNA who was assigned to R1 had already left at 6:45AM, so the front desk called V8 (Does not remember who) at approximate at 7:05AM and stated R1's ride for an appointment was here. V8 stated he asked the other night nurse (cannot remember name) about R1's appointment and what V8 was needed to do before R1 left for appointment. V8 stated the night nurse told V8 to print R1's face sheet. V8 then asked another CNA (cannot remember name) to get R1 ready for her appointment. V8 stated the CNA got R1 ready, put R1 in a wheelchair and took R1 downstairs to the front desk for pick up to appointment. V8 stated he did not have any information if R1 needed an escort to appointments and during change of shift, the nurse handing over to him for the night shift told V8 that there were no residents with appointments the following morning. V8 stated he is an agency nurse, and this was the first time working at the facility and got a quick orientation from the nurse handing over to him. V8 stated he was not told where to find things like communication book, so he trusted what the nurse he was working with told him and did not know R1 needed an escort to appointments.On 09/30/2025 at 2:48PM, V10 (Lead receptionist) stated he was at the front desk when R1